STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 9/27/16 through 9/29/16. Five complaints were investigated during the survey. Significant Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 150 certified bed facility was 125 at the time of the survey. The survey sample consisted of 24 resident reviews; 21 current residents (Residents #1 through #21) and 3 closed record reviews (Residents #22 through #24).	F 000		
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.13(c)(1)(ii)-(iii), (c)(2) - (4) The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law	F 225		11/4/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/21/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1 through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on a clinical record review, staff interviews and facility documentation, the facility staff failed to provide evidence they investigated an injury of unknown origin, as well as report this injury to the State Survey and certification agency for 1 of 24 residents (Resident #23) in the survey sample and the facility staff failed to obtain a criminal background report for 2 of 25 hired employees. Resident #23 was identified with bruising of an unknown source to her right leg. There was no documented evidence that the facility attempted to identify the origin of these bruises in light of a recent injury that resulted in a fractured right Humerus/elbow. The findings include: Resident #23 was admitted on 6/24/06 with	F 225	F225: How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #23 was discharged on 12/30/2014 Staff member #1□s background check was received on 9/29/2016 and staff member #2□s background check was received on 9/29/2016 How the facility will identify other Residents having the potential to be affected by the same deficient practice. All residents have the potential to be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 2 diagnoses that included delusional disorder, Alzheimer's disease, dementia with behavioral disturbances, Schizophrenia disorder and depressive disorder. The resident was discharged on 12/30/14 and did not return to the nursing facility. Resident #23's Minimum Data Set (MDS) assessment dated 11/27/14 coded the resident with short and long term memory problems and severely impaired in the skills needed for daily decision making. She was coded for delusions, psychotic disorder other than Schizophrenia, as well as Schizophrenia and Alzheimer's disease. She was coded impaired on one side of lower extremity in Range of Motion (ROM). The resident was assessed to require extensive assistance for dressing and personal hygiene. Transfers and bed mobility was coded as extensive assistance with two person physical assist. The care plan dated 12/4/14 identified the resident with Schizophrenia and schizoaffective disorder and had the potential to exhibit inappropriate behaviors related to the disorder, as well as her overall inability to perform Activities of daily Living independently related to debility. The goals the staff set for the residents were that she would maintain/obtain appropriate personal care. Some of the approaches the staff would implement to accomplish this goal included have resident attempt all movements by self before offering assistance, monitor for inappropriate behaviors and document every shift and as needed, approach warmly and positively at all times, provide consistent care givers, provide structured care and offer reassurance to Resident as necessary.	F 225	affected. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur. 100% of staff in all departments will be in-serviced on the Abuse Prevention/Reporting Policy and Procedure as well as the Investigating Unknown Injuries Policy by the Administrator, Director of Nursing, Assistant Director of Nursing, or Staff Development Coordinator by 11/13/2016. All reports of abuse and injuries of unknown origin will be reviewed by the Administrator, Director of Nursing, Assistant Director of Nursing, and Social Services Director to ensure investigation is completed based upon policy and procedure and appropriate notifications are made to the state, physician, families, and law enforcement (if indicated). After in-servicing is completed, failure by staff to report or comply with investigative procedures will result in progressive disciplinary action up to and including termination. 100% of active employees will be audited for the presence of criminal background checks by 10/24/2016. If a criminal background check is found to be missing, the employee will be removed from the schedule and placed on leave until a copy is received. For all new hires, if criminal background checks are not received by the 15th day after hire, the staff member will be removed from schedule and placed on leave until background check is received. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 3 The nurse's notes dated 12/20/14 at 7:50 a.m., written by the previous Unit Manager (no longer employed by the facility), indicated a bruise and scab was observed on Resident #23's right lower leg when the resident returned from the Emergency Room on the 3/11 shift, which was reported off to this nurse from the 11/7 nurse. The off going nurse and Unit Manager observed the right leg bruise to have increased in size. The physician ordered an X-ray to the right tibia/fibula. The X-ray results were negative for fracture. There were no nurse's notes entered on the 3/11 shift or the 11/7 shift about the aforementioned bruise. The resident had previously been transferred and evaluated to the ER on 12/19/14 around 4:00 p.m. for and injury of unknown source with swelling and bruising to the right arm/elbow. The ER nurse's notes and skin assessment noted a dark reddened area on the right outer leg with a scabbed over area, as well. On 9/28/16 at 4:40 p.m., a telephone interview was conducted with the previous Director of Nursing (DON). She stated once she was notified the following day on 12/19/14 about bruising of Resident #23's right shoulder, she began her investigation, but did not know anything about a bruise to the right leg. She stated, "If I or the Administrator had been informed of a bruise to the right leg and no one was sure of how it originated, an incident report would have been generated and an investigation would have been started immediately, especially since she had the injury with fracture to her right shoulder on 12/18/14."	F 225	Human Resources Manager will then contact state police to inquire about status. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. The Administrator or Director of Nursing will report Allegations of Abuse, Neglect, Misappropriation, or Injuries of Unknown Origin Investigations to the monthly Quality Assurance Performance Improvement Committee. Quality Assurance Performance Committee members include: Committee Chairperson □ Administrator; Director of Nursing Services; Assistant Director of Nursing Services; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director. The Administrator and/or designee (Director of Nursing Services or Assistant Director of Nursing Services) will report findings of investigations in the monthly Quality Assurance and Performance Improvement meeting ongoing for further recommendation and/or suggestions and follow-up as needed. The Human Resource Manager will report to the monthly Quality Assurance Performance Improvement Committee the results of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 4 On 9/29/16 at 11:25 a.m., an interview was conducted with the current Administrator, current DON and QA Consultant nurse (via telephone). Two State surveyors were present during the interview. None of the aforementioned Administrative staff were employed at the time of Resident #23's identified right leg bruise. The Administrator and the DON stated they could not find in any file where the right leg bruise had been investigated or reported to any local or State agencies to include the Office of Licensure and Certification. All present stated if there were identified bruises, but no origin of the bruises, they should have been investigated and a facility reported incident initiated especially since there had been a recent right arm/elbow fracture identified on 12/19/14 from an injury that occurred on 12/18/14. Resident #23 was again transferred to the local ER for Shortness of breath on 12/30/14. The nurse's skin assessment upon admission to the ER revealed a scabbed area to the right upper thigh and a large area of ecchymosis on the right outer leg. On 9/29/16 at 3:15 p.m., a telephone interview was conducted with Resident #23's Responsible Party (RP). The Responsible Party (RP) stated she was aware of the bruise to the right leg, but was never informed of the outcome of any investigation the facility may have conducted. No further information was provided During the pre-exit meeting conducted on 9/29/16 at 7:30 p.m. The facility's policy and procedure titled "Abuse	F 225	background audit for current employees and then ongoing for all new hires for further recommendations and follow up as needed. Completion Date: 11/4/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 5	F 225		

Investigations" dated 2010 indicated all reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management. The policy titled "Abuse Prevention/Reporting" dated 2013 indicated a report would be sent to the local State agencies within 24 hours of the incident and a facility internal investigation would be completed and summary of the investigation reported to the State within 5 working days.

2. The facility staff failed to follow their Abuse Screening process by not obtaining a clear criminal record report for 2 of 25 employees within 30 days of hire according to State and Federal Regulations.

On 9/29/16, 25 employee records were reviewed for criminal background checks within 30 days of hire. The employee record for Employee #1 with a hire date of 8/24/15 revealed a one page only Criminal History Request Response dated 7/28/16. There was no documented response available from the Department of State Police for the facility to determine if the employee had or did not have a criminal history. On 9/29/16 the facility Human Resource Manager ran another criminal background check on Employee #1 which indicated under Status: "No Identifiable Record". The employee record for Employee #2 with a hire date of 7/7/16 revealed in capital letters "PRINTS REQUIRED FOR PROPER ID" (identification). On 9/28/16 the facility Human Resource Manager ran another criminal background check on Employee #1 which indicated under Status: "TRANSACTION IS BEING PROCESSED". Both employees were currently employed at the facility during the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	**340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 6	F 225		

On 9/29/16 at approximately 3:30 p.m. an interview was conducted with the Human Resource Manager regarding the missing Criminal Background checks for Employee #1 and Employee #2. Regarding Employee #1 Human Resource Manager stated, "I only had the first page of the report, it comes by mail. The CEO (Chief Executive Officer) gets it first and then it comes to me. I never got the other page. The CEO didn't tell me not to let her work, she only gave me one page. I called the Department of State Police and they stated they don't keep in files the result and they are not able to send a copy. I re-run the criminal background on 9/29/16." Regarding Employee #2 Human Resource Manager stated, "The background report came with status Prints required for proper ID. I called the Department of State Police and they stated that I was supposed to receive a letter. I didn't receive any letter, so I re-run the criminal background on 9/28/16. I will receive a letter from the state within 7 days from 9/28/16."

On 9/29/16 at approximately 3:40 p.m. an interview was conducted with the Administrator regarding the above findings. The Administrator was asked what would he have expected. The Administrator stated, "I would expect for the staff to follow-up with the criminal background checks to make sure they are complete and employees are qualified to work."

The facility policy titled "Background Screening Investigations" revised April 2013 documented in part, as follows:

Policy Statement: Our facility conducts employment background screening checks, reference checks and criminal conviction

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 7 investigation checks on individuals making application for employment with our facility. Policy Interpretation and Implementation: 1. The Personnel/Human Resources Director, or other designee, will conduct employment background checks, reference checks and criminal conviction checks (including fingerprinting as may be required by state law) on persons making application for employment with this facility. Such investigation will be initiated within two days of employment or offer of employment. 4. Should the background investigation disclose any misrepresentation on the application form or information indicating that the individual has been convicted of abuse, neglect, mistreatment of individuals, and/or theft of property, the applicant will not be employed and/or will be terminated from employment. On 9/29/16 at approximately 7:35 p.m. a pre-exit interview was conducted with the Administrator, the Director of Nursing, and the Regional Nurse Consultant where the above findings were shared. Prior to exit no further information was provided.	F 225		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.20(d)(3), 483.10(k)(2) The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or	F 280		11/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 8 changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and resident and staff interview it was determined that the facility staff failed to revise Resident 13's care plan following an elopement from the facility. Resident #13 was one of 24 residents in the survey sample. The findings included: Resident #13 eloped from the facility on 8/7/16. He was picked up by the police and taken to the hospital for overnight observation. Following his return his care plan was not revised to include new interventions to prevent another elopement. The resident was 64 years old and was admitted to the facility on 3/31/16. His diagnoses included a stroke, high blood pressure and diabetes.	F 280	F 280: How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #13□s care plan was updated on 9/29/16 How the facility will identify other Residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What measure will be put in place or systemic changes made to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 9 The 7/7/16 and 9/28/16 quarterly MDS (minimum Data Sets) evidenced the resident had moderate cognitive deficits with a brief interview for mental status of 9 out of 15 indicating moderate cognitive impairment. However, in activities of daily living the resident was independent requiring only oversight. On admission the resident was evaluated for an elopement risk and was determined to not be a risk. On 4/7/16 he was evaluated again and several things had changed. Resident #13 was determined to have some cognitive deficits, communication issues, the resident had verbally expressed a desire to go home or packed his belongings, wandering behaviors identified, and the resident had been admitted in the last 30 days. On 9/28/16 the resident was interviewed at 10:50 am. He was resting in bed but seemed willing to talk. The resident remembered taking "a walk", "just started walking". On 4/14/16 a care plan for "Wanders with exit seeking behaviors" was indicated. The goal was "Resident will not leave the facility unattended or have injury related to behavior." The approaches included; observe resident's whereabouts frequently, monitor wandering devices and check for placement and function, if resident elopes implement facility protocol for locating resident, provide resident with diversion activities and socialization, review medications frequently and give as ordered, document and notify MD of any episodes and resident has a wanderguard. The care plan was reviewed on 7/14/16 and continued to 10/12/16 without change and to	F 280	that the deficient practice will not recur. The Director of Nursing, Assistant Director of Nursing, or Staff Development Coordinator will in-service all licensed nurses by 11/4/16 on the facility□s Elopement Response Policy which indicates that the resident□s plan of care shall be revised to include interventions to prevent further elopement or the potential for elopement. The Director of Nursing, Assistant Director of Nursing, or Staff Development Coordinator will also in-service all licensed nurses on signing assessment forms as they are completed by 11/4/16 All residents care plans who are at risk of elopement will be reviewed by the Interdisciplinary Team by 11/4/16 to ensure care plans are appropriate and updated. The Administrator or Director of Nursing will keep an Elopement Log that will monitor all attempted or actual elopements for updated, appropriate interventions documented on the plan of care. This will be ongoing. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. The Administrator or Director of Nursing will present the results of Elopement Log to the monthly Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson □ Administrator; Director of Nursing; Assistant Director of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 10 continue goal. On 8/7/16 the resident left the facility unattended. Policy was followed and search of the grounds was conducted and then the local police were informed. The police did locate the resident and he was taken to a local hospital for overnight observation. The resident was not injured. When he returned on 8/8/16 the risk assessment was again completed. In addition to the above changes the area for the resident having left the facility without informing staff was checked and the section regarding family concerns that the resident might try to leave was also checked. The person completing the 8/8/16 risk assessment did not sign the form. On 9/29/16 at 5 p.m. this self reported incident was discussed with the administrator. The administrator stated that they were never able to determine how the resident left the building undetected. At the time of the incident the resident walked without any assistive devices and probably went out the door with a visitor. At 8 p.m. the care plan was discussed with the Director of Nurses, she stated she thought it had been revised as a copy had gone with the facility reported incident. A copy of the Care Plan was included but was not revised following the resident's elopement. On the bottom of the elopement risk form is a list of potential interventions. Some interventions not tried were behavior logs, tapes with messages from his family, bed alarm (resident last seen in bed), recreational activities, music, personalized room, a secure unit (facility does have one) and disguising unit exits with visual barriers.	F 280	Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) ongoing for further recommendations and/or follow up as needed. Completion Date: November 4, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.25 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview it was determined for Resident #11, one of 24 residents in the survey sample, that facility staff failed to assure he received appropriate treatment for a non pressure wound with slough and received a wound culture as ordered by his physician. The findings included: The order for the wound treatment was not changed as the wound worsened and the wound culture was not completed . The current order for the half dollar size wound on the top of the resident's left foot was Bacitracin Ointment daily. The non pressure wound began as a blister and was identified on 9/1/16. When observed by the surveyor on 9/27/16 and 9/28/16 the wound bed was covered in slough. A wound culture would determine if the wound was infected and if so, the organism and the antibiotic that would be effective for treating the infection. (a) Resident #11 was 69 years old and admitted to the facility on 7/16/2015. His admission	F 309	F309: How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #11□s wound was fully assessed with measurement□s and an appropriate treatment order received on 9/26/16. Wound culture was obtained on 10/6/2016. How the facility will identify other Residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur. All residents will have a skin assessment	11/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 12 diagnoses included weakness secondary to a spinal cord injury (gunshot wound to chest), stroke affecting his left side, high blood pressure and diabetes. The 7/7/16 annual Minimum Data Set (MDS) evidenced the resident was cognitively intact with a score of 15 out of 15 on the brief interview for mental status. For activities of daily living he was extensive assistance of one person., except for eating which was independent after set up. The resident was incontinent of bladder but continent of bowel. The resident frequently refused care. On 9/27/16 at 10:30 am Resident #11 was observed in the courtyard smoking. On his right foot he wore a sock and shoe, his left foot was bare and rested on the ground. On the top of the left foot was an uncovered half dollar size open area with a yellow wound bed. The resident was interviewed and stated that he had removed the dressing himself with a pair of scissors he kept in his room. The resident continued that he was allowed the scissors because of his hand weakness and it allowed him to independently open packaged items. The top of the wound appeared shiny and the resident confirmed that he had put an ointment (kept in his bedside table) on the wound that morning. The resident's hands were soiled and his nails long with dark debris under all nails. Resident #11 freely admitted staff encouraged him to keep the wound covered and he had refused nail care but was thinking of letting staff cut and clean his nails. Resident #11 stated his disliked the dressing because his foot felt, "confined."	F 309	completed by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Wound Nurse, or Unit Managers to ensure that all skin issues have been identified, physician and family notification completed as necessary, plan of care developed or revised, reviewed, and/or updated as necessary. All wounds will be staged, measured, and treatment orders will be in place as appropriate. This will be completed by11/4/16. All licensed nursing staff will be in-serviced by the Director of Nursing, Assistant Director of Nursing, or the Staff Development Nurse on the Prevention of Pressure Ulcers Policy, Resident Examination and Assessment Policy, and the Notification of Change Policy by 11/4/16. A Pressure Ulcer Log will be completed by the Wound Nurses and utilized by the Interdisciplinary Team 5 x/ week in the morning Stand Up Meeting to ensure documentation on wounds are occurring weekly, labs/cultures ordered are obtained, treatments are in place and appropriate, care plan updated, and MD/Family notifications are completed for residents with pressure ulcers ongoing. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. The Director of Nursing, Assistant Director of Nursing, or Wound Care Nurse will report findings of the Pressure Ulcer Log and weekly documentation compliance to the monthly Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 13 At 11:30 am the resident was visited in his room; his foot was newly wrapped with Kerlix. The resident showed the surveyor what he was applying to his wound; it was A and D ointment. Individual packets were observed in the drawer of the bedside table and the scissors used to cut the packets open. Open packets, still containing ointment, were observed in the drawer. The following morning at 10:15 am the resident was observed in the courtyard (smoking) with his bare left foot, wound uncovered, on the ground. Two surveyors observed the wound that appeared the same as the previous day, half dollar size with a yellow, gooey substance covering the entire wound. The peri wound (area surrounding the wound was slightly raised). The resident stated the wound had been very painful and just in the last couple of days he received a narcotic for pain and it was very effective. The resident's clinical record was reviewed for development of the wound and treatment. Review of the nursing notes did not evidence a description of the wound. On the morning of 9/28/16 at approximately 11:30 am the Assistant Director of Nursing was requested to provide a wound tracking record for Resident #11. The ADON did not provide the tracking sheet until the following morning with the following information. PRESSURE INJURY SHEET and TELEPHONE ORDERS 9/1/16.. Blister lt (left foot) vascular, telephone order (TO) to "wrap (L) foot with Kerlix daily and culture blisters (sic) if they rupture.";	F 309	Assurance Performance Improvement Committee (members include: Committee Chairperson □ Administrator; Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) ongoing for further suggestions and/or follow up as needed. Compliance will be by November 4, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 14	F 309		

9/17/16 blister ruptured, 4.0 X 3.8 cm (centimeters 2.2 cm = 1 inch);
9/20/16 TO, "apply Bacitracin to ruptured blister to (L) foot daily";
9/21/16 2.1 X 2.0 cm.

Review of the nursing notes evidenced that any additional descriptions of the wound were not documented until 9/26/16, "measurements : 2.1 cm X 2 cm. During an 9/29/16 10:00 am interview with the ADON where she was requested to provide additional descriptions of the wound, she stated the resident refused treatment and her nurses could not "guess at measurements." The PRESSURE INJURY SHEET from 9/1/16 to 9/21/16 evidenced the resident refused Kerlix wrap daily leaving the wound visible for a nursing assessment as it was for the surveyors on 9/27/16 and 9/28/16. On 9/26/16 the wound was dressed, "Bacitracin and Kerlix applied to foot."

The PRESSURE INJURY SHEET was blank of any description, such as granulating tissue, or slough.

From the time the blister ruptured on 9/17/16 until the surveyors observed the wound on 9/27/16 there was no documentation that the wound contained slough. The MDS describes Slough as, "yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous." Slough may appear in non pressure wounds as well as pressure wounds.

A policy on wound treatment was requested at the time the pressure injury sheet was received; the policy "PRESSURE INJURY TREATMENT" was provided. No additional policy information was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 15	F 309		

received and the team was told by the Director of Nursing to refer to the Pressure Ulcer treatment policy for "debridement and slough". The Policy did contain information on debridement and slough. Under Stage 4 Protocol #2 Debride slough/eschar, a.) select the method of debridement most appropriate to the resident's condition and goals (note this is a physician task) b.) Sharp, mechanical, enzymatic and or autolytic debridement techniques. No definitions of the debridement methods were included; however; in the article below debridement is defined.

WOUND AND PRESSURE ULCER MANAGEMENT (Johns Hopkins Medicine from www.hopkinsmedicine.org), under assessment for Venous ulcers advices, "An assessment of the wound should be done weekly and be used to drive treatment decisions. Wound assessment includes: location, class/stage, size, base tissue, exudates, odor, edge/perimeter, pain and an evaluation for infection".

"Types of Debridement" Autolytic debridement is lysis of necrotic tissue by the body's own white blood cells and enzymes. Chemical debridement is accomplished by topical use of enzymes. These enzymes are available in a variety of products. Mechanical debridement can be a wet to dry dressing, a whirlpool or a pulse lavage. Sharps debridement is with a scalpel and forceps.

Review of the physician's progress notes and orders evidenced the resident was seen on 9/26/16, the only description of the wound was, "Left medial malleolus ulcer." The treatment remained Bacitracin oint and wrap with Kerlex.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 16 On 9/29/16 at 7:30 am the resident was seen again (at the request of the facility) the order remained the same, except the wound was to be cleaned with Dermal Wound cleanser (DWC) At 2 pm LPN #10 was interviewed and stated that Resident #11's attending physician had been in that morning and that he had looked at the wound. LPN #10 stated that the wound now had slough and that in her opinion the physician should have done more for the wound. The LPN stated she was not sure how long the wound bed had slough, she replied, "several days, maybe more." On 9/29/16 at 8 pm the corporate nurse was interviewed on the telephone regarding Bacitracin as a treatment for a wound bed with slough. The corporate nurse stated it was not an appropriate treatment. The nurse also stated that weekly assessments with measurements and descriptions was her expectation. (b) The physician's orders for the wound culture was first written on 9/1/16 when the left foot blister was identified and instructed the staff to "culture" the blister if it ruptures. Review of the clinical record did not evidence that a wound culture was completed when the blister ruptured on 9/17/16. The missing wound culture was discussed on 9/29/16 at approximately 11;30 am with the ADON and she was shown the order in the resident's chart. The ADON stated she would research the issue and get back to the surveyor. Later in the day the ADON confirmed that the culture had not been completed as ordered.	F 309		
F 314	TREATMENT/SVCS TO PREVENT/HEAL	F 314		11/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314 SS=G	Continued From page 17 PRESSURE SORES CFR(s): 483.25(c) Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, clinical record review, and review of the facility's policy the facility staff failed to ensure the necessary treatment, care and services were provided to prevent development of a pressure ulcer for 1 of 24 residents (Resident #7), in the survey sample resulting in harm. Resident #7 developed a facility acquired pressure ulcer to the right heel which was first assessed at an advanced stage (with eschar). The findings included: Resident #7 was originally admitted to the facility 8/1/11 and readmitted 8/31/15 after an acute hospital visit. The current diagnoses included: anemia, hypertension, stroke with hemiparesis (weakness on one side), dementia, depression, a seizure disorder and benign prostatic hyperplasia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/30/16 coded the resident as not	F 314	F 314: How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #7□s undated physician orders were clarified, re-written, and dated on 9/29/16. Resident #7□s wound was assessed by the physician and Unit Manager and an appropriate order for treatment was obtained on 10/7/16. The primary physician was in-serviced by the Administrator and Director of Nursing on 10/7/16. regarding dating his notes, writing timely progress notes after seeing and assessing residents, signing his orders timely, and assisting in identifying interventions for pressure ulcer prevention appropriately. How the facility will identify other	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 18 having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as moderately impaired for daily decision making. The resident was also coded for not being able to speak and rarely to never understanding what's communicated to him and rarely to never capable of making himself understood. The resident was also coded as not exhibiting mood or behavior problems. Resident #7 required extensive assistance of 2 person with bed mobility and transfers, extensive assistance of 1 with dressing, eating, and toileting, total care of 1 with personal hygiene and total care of 2 with bathing. The resident was coded totally incontinent of bowels and bladder. In section "M" (Skin conditions) of the 8/30/16 MDS assessment Resident #7 was coded as at risk of developing pressure ulcers at "M0150". Resident #7 was also coded as not having venous or arterial ulcers, but having an open lesion other than a pressure ulcer on the foot. The resident was coded for having a pressure reducing device to the chair and bed, being on a turning/repositioning program, receiving nutrition or hydration interventions to manage skin problems, applications of ointments/medications other than to feet and application of dressings to the feet at "M1200I". A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. The Braden scale dated 9/6/16 revealed Resident #7 had a high risk for skin breakdown. The Braden score was 12. The predicting tool	F 314	Residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur. All residents will have a skin assessment completed by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Wound Nurse, or Unit Managers to ensure that all skin issues have been identified, physician and family notification completed as necessary, plan of care developed or revised, reviewed, and/or updated as necessary. All wounds will be staged, measured, and treatment orders will be in place as appropriate. This will be completed by 10/7/16. All licensed nursing staff will be in-serviced by the Director of Nursing, Assistant Director of Nursing, or the Staff Development Nurse on the Prevention of Pressure Ulcers Policy, Resident Examination and Assessment Policy, and the Notification of Change Policy by 11/4/16. A Pressure Ulcer Log will be completed by the Wound Nurses and utilized by the Interdisciplinary Team 5 x/ week in the morning Stand Up Meeting to ensure documentation on wounds are occurring weekly, labs/cultures ordered are obtained, treatments are in place and appropriate,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 19 revealed the resident was with very limited ability to respond to pressure related discomfort, the skin is occasionally exposed to moisture, the resident is chair fast, completely immobile, and receives nutrition by tube feedings. Resident #7 had undated physician orders for an air mattress, wedge while in bed for positioning, boots to bilateral feet for preventative measures at all times as tolerated except during activities of daily living and skin assessments, skin prep to bilateral heels every shift, turn and reposition every 2 hours and apply zinc oxide cream every shift as needed to buttock. Pressure ulcer prevention requires assessment of the resident's risk factors and development of a plan to reduce or eliminate the risk factors. These include constant monitoring as care is rendered for redden areas especially over bony prominences, protecting the skin from incontinence episodes, lifting the resident off surfaces use of a draw sheet, limiting elevation of the head to 30 degrees, establishing and implementing an individualized turn schedule, notifying appropriate staff of changes identified in the skin.(Pottery & Perry 7th edition, chapter 48 page 1303) The clinical record revealed a nurse's note dated 9/23/16 at 2:00 p.m. which read; Resident has an opened wound noted to the right foot/heel. Applied wet-to-dry dressing to wound and applied Kerlix (woven gauze). No signs/symptoms of distress noted. Will continue to monitor. The clinical record did not reveal the physician was notified neither was a physician's order for the wet-to-dry dressing or any other wound care	F 314	care plan updated, a weekly physician progress note, and MD/Family notifications are completed for residents with pressure ulcers ongoing. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. The Director of Nursing, Assistant Director of Nursing, or Wound Care Nurse will report findings of the Pressure Ulcer Log and weekly documentation compliance to the monthly Quality Assurance Performance Improvement Committee (members include: Committee Chairperson □ Administrator; Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) ongoing for further suggestions and/or follow up as needed. Compliance by November 4, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 20	F 314		

order identified in the clinical record for 9/23/16.

On 9/24/16 at 2:30 p.m., a nurse's note read; "writer informed by Unit Manager to follow-up with (name of the physician) regarding the right heel wound and treatment. Writer assessed right heel and noted open area measured 5.5 centimeter by 5.0 centimeters by 0.3 centimeters, wound bed pink, beefy with a moderate amount of bloody drainage. Surrounding tissue soft; small eschar to edge. No odor noted. Patient's heels elevated, turned and repositioned as tolerated. (name of the physician) notified with new order to cleanse site with Dermal Wound Cleanser and apply Exuderm every 3 days and as needed. Writer also called to notify next of kin with no YR (sic). Writer also noted multiple small blisters to right arm, intact fluid filled, new order skin prep every shift."

Eschar is dead tissue that sheds or falls off from healthy skin. It's caused by burns and also occurs in pressure wounds (bedsores). Eschar is typically tan, brown, or black, and may be crusty. (http://www.healthline.com/symptom/eschar)

Exuderm dressings are sterile hydrocolloid wound dressings designed for all stages of wounds. Exuderm dressings create a moist environment to encourage wounds to heal. (https://www.medline.com/product/Exuderm-Thin-Hydrocolloid/Hydrocolloid-Dressings/Z05-PF00175)

Skin Prep is a liquid film-forming dressing that, upon application to intact skin, forms a protective film to help reduce friction during removal of tapes and films. (http://www.smith-nephew.com/professional/prod

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 21	F 314		

ucts/advanced-wound-management/skin-prep/)

Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).
(http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/)

Stage 3 Pressure Injury: Full-thickness skin loss
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.
(http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/)

Resident #7 had an undated physician's order for skin assessments/body checks every Tuesday on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 22	F 314		

the 3 - 11 p.m. shift.

Resident #7's skin assessment report revealed no entries on 8/23/16 and 8/25/16. The 9/1/16 entry read; skin not intact - existing, 9/8/16 entry read; skin intact, 9/15/16 entry read; skin not intact - existing, 9/22/16 entry read; skin not intact - new. There was no corresponding documentation explaining what the existing or new skin areas were or their locations.

An interview was conducted with the Director of Nursing (DON) on 9/28/16 at approximately 3:45 p.m. The DON stated they had not investigated the wound to Resident #7's right inner heel but they believed it was a result of vascular problems and heat produced by use of the prevalon boots.

Prevalon boots give patients the most advanced protection against heel pressure ulcers and foot drop. Prevalon helps minimize pressure, friction and shear on your patient's feet, heels and ankles. By elevating the foot and separating the heel from the mattress, it delivers total heel pressure relief (http://www.sageproductsglobal.com/en/prevalon.cfm).

An interview was conducted with LPN #4 on 9/29/16 at approximately 6:05 p.m., LPN #4 documented the skin assessments results on 9/1/16, 9/8/16, and 9/15/16. LPN #4 stated she never inspected Resident #7's skin but she did document the information provided to her by LPN #7. LPN #4 stated she documented for LPN #7 because she told her she did not have a password to use the skin assessment report software.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 23	F 314		

An interview was conducted with LPN #7 by telephone on 9/29/16 at approximately 6:45 p.m. LPN #7 stated she was responsible to perform skin assessments on Resident #7 and she did complete them and told another nurse by mouth the results to document. LPN #7 stated on 9/22/16 the resident had open areas to the top of the left foot and the heel of the right foot and she was supposed to document in the chart the description of the open areas and measure them but she failed to do that. LPN #7 stated "it's my fault for not documenting, if you didn't document you didn't do it".

Resident #7's care plan dated 9/24/16 read: "Alteration in skin integrity Stage II pressure injury to right lateral foot. The goals were; no further breakdown until next review. Nutrition support to be given until next review. Will not have an impact on socialization until next review." The interventions were: Medications and treatments as ordered. Notify physician of any changes. Weekly skin assessments by nurse. Certified Nursing Assistant (CNA) to check skin daily when changing and bathing resident and notify nurse. Provide pain medication as scheduled and as needed. Educate resident on skin integrity, nutrition and prevention measures. Monitor dressing to ensure clean and dry every shift. change as needed and as ordered. Encourage socialization. See dietary care plan (The Nutrition care plan had been updated since the resident acquired the right foot pressure ulcer).

Resident #7 was observed in bed on 9/28/16 at approximately 11:05 a.m. The resident was lying on the left side on a low air loss replacement mattress. Contractures were noted of all extremities and blue Prevalon boots were on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 24	F 314		

bilateral lower extremities. Licensed Practical Nurse (LPN) #1 entered the room to provided wound care to Resident #7's right heel including the inner foot pressure ulcer. CNA #10 stated she had positioned Resident #7 on the left side when she came in to work with the resident. Positioning the resident on the left side prevented LPN #1 from having a direct view of the pressure ulcer. CNA #10 held Resident #7's right leg up and LPN #1 removed an Exuderm dressing dated 9/27/16 3 - 11 p.m. and the wound began to bleed from the wound bed. LPN #1 had to look under and up to see the pressure ulcer and render care. LPN #1 sprayed the pressure ulcer with wound cleanser and wiped the wound with 4 by 4 gauze and proceeded to dry the wound. Using a cotton tip applicator, LPN #1 applied Hydrogel wound gel to the wound, applied 4 by 4 gauze and wrapped the wound in kling roll gauze and tape with the date on it to hold it all together. The right inner heel pressure ulcer was observed with dark tissue around the edges from approximately 10 o'clock to 2 o'clock.

Hydrogel is ideal for dry-to-moist clean wounds. Helps create a moist wound environment. Balanced formulation Easy irrigation Indications: pressure ulcers, partial and full-thickness wounds, leg ulcers, surgical wounds, lacerations, abrasions and skin tears, and first- and second-degree burns (www.medline.com/product/Skintegrity-Hydrogel/Gel/Z05-PF00182).

The facility's policy titled "Pressure Ulcer Risk Assessment" with a revision date of October 2010 under Assessment: skin assessments will be assessed for the presence of developing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 25	F 314		

pressure ulcers on a weekly basis or more frequently if indicated. Monitoring: staff will maintain a skin alert performing routine skin inspections daily or every other day as needed. Nurses are to be notified to inspect the skin if changes are identified. Under Prevention of Pressure Ulcers General Guidelines: The facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and family and addressed.

The primary physician came to the facility 9/29/16 and wrote a progress note. There was no time documented on the progress note. It read; (name of resident) developed a right medial beneath the malleolus and extending to the bottom of the foot on 9/24/16. Measurement 5.5 centimeter by 5.0 centimeters by 0.3 centimeters, initial treatment Dermal Wound Cleanser and apply Exuderm but later changed to Hydrogel and cover with Border gauze. He has a flexion contracture and pushes his leg against his booties. He had a previous Peripheral Vascular Laboratory (PVL) 4/2015 with arterial disease of his distal common femoral artery left and right consistent with mild arteriosclerotic disease. Repeat study today shows continued arterial disease with mild arteriosclerotic disease. He has a decreased dorsalis pedis pulse and a posterior tibial pulse that is more weak. Impression flexion contracture with arteriosclerotic disease exacerbating a medial stage II malleolus and sole of foot ulcer.

The DON stated no staff member could confirm the physician assessed Resident #7's pressure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 26 ulcer while in the facility on 9/29/16 or only viewed nurse's notes and requested PVL reports. The physician did not describe the type of tissue identified in the pressure ulcer during the assessment on 9/29/16 and the same measurements were documented in both assessments. The physician stated the resident pushes against the booties but no action was taken regarding the Prevalon boots. The above findings were shared with the Administrator, Director of Nursing and the Corporate Quality Assurance Nurse by telephone on 9/29/16 at approximately 7:35 p.m. for the pre-exit conference. The Corporate Quality Assurance Nurse stated prevention of pressure injuries is first priority and healing pressure injuries if one develops. The Corporate Quality Assurance Nurse stated it is also the facility's expectation for skin assessments to be completed and documentation of findings of open areas including location, description, tissue type, measurements, drainage, indication of pain, notification of physician and responsible party. The Corporate Quality Assurance Nurse also stated first identification of pressure ulcers with eschar is not desirable. The Corporate Quality Assurance Nurse stated there was a system failure with this resident and the interventions are to train the nurses, use a weekly wound log, identify the cause of the pressure, keep the physician informed and for the physician to assess and help identify interventionsfor pressure injury prevention and management.	F 314		
F 315	NO CATHETER, PREVENT UTI, RESTORE	F 315		11/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315 SS=D	Continued From page 27 BLADDER CFR(s): 483.25(d) Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, for 1 resident (Resident #4) of 24 in the survey sample the facility staff failed to ensure Foley catheter was secured after the provision of catheter care. The findings included: Resident #4 was admitted to the facility on 3/2/12 with a readmission on 4/11/16. Diagnosis for Resident #4 included but are not limited to Urinary Retention. Resident #4's Quarterly Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 7/14/16 coded Resident #4 with a BIMS (Brief Interview for Mental Status) score of 6 indicating a severe cognitive impairment. In addition, the Quarterly Minimum	F 315	F315: How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. A leg strap was placed to secure Resident #4□s catheter on 9/30/16 How the facility will identify other Residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur. 100% of licensed nurses and Certified	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 28 Data Set coded Resident #4 requiring Extensive Assistance with one staff person assistance for: Dressing, Eating, Hygiene. Resident #4 was coded as requiring Total Dependence with one staff person assistance for Bathing. Resident #4 was coded as having an indwelling catheter and was coded as Always Incontinent of Bowel functioning. Resident #4's 4/26/16 Care Plan Problem Potential for urinary tract infection related to presence of indwelling catheter - dx (diagnosis) of urinary retention documented the following intervention: Tape catheter to thigh Resident #4's 4/12/16 Physician order documented the following: Clean Foley catheter with soap and water every shift and as needed. Resident #4's 6/23/16 Physician Recertification note documented the following: "He (Resident #4) complained of some urinary voiding difficulty and had a mixed urine culture in June and was started on Cipro* for urinary tract infection with the addition of Macrobid* for enterococcus*. He continues to be followed frequently for urinary symptoms and in August had Klebsiella ESBL*. This was treated with fluids and p.o. (by mouth) tetracycline* until IV (intravenous) Primaxin* was able to be started by PICC* line. He was transferred to the ER in August for nausea and vomiting and chest discomfort without any acute findings. He developed another urinary tract infection in September with Klebsiella ESBL sensitive to Primaxin* but he refused PICC* line placement and was started on tetracycline*. Eventual	F 315	Nursing Assistants will be in-serviced by 11/4/16 on the Urinary Catheter Care Policy which indicates securing of Foley catheters with a leg band. The Director of Nursing, Assistant Director of Nursing, or Staff Development Coordinator will conduct the in-servicing. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers will audit all residents with Foley catheters for placement of leg straps 2x/week x 4 weeks, then weekly x 4 weeks, then monthly x1. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. The Director of Nursing, Assistant Director of Nursing, Staff Development Nurse will report findings of the Foley Catheter Audit to the monthly Quality Assurance Performance Improvement Committee (members include: Committee Chairperson □ Administrator; Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) x 4 months for further suggestions and/or follow up as needed. Compliance by 11/4/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 29	F 315		

cultures on his urine proved to be Proteus* and he was treated with Rocephin IM*. Urological evaluation has been completed by (Physician) in mid October and felt to he had urinary retention with a urethra stricture not passable. He (physician) suggested a suprapubic* tube. (Resident #4) refused."

Cipro: Medline Plus documents: Cipro is used to treat or prevent certain infections caused by bacteria
Macrobid: Medline Plus documents: medication used to treat urinary tract infections
Enterococcus: Center of Disease Control documents: Enterococci, leading causes of nosocomial (hospital acquired) bacteremia ... urinary tract infection, and are becoming resistant to many and sometimes all standard therapies.
Klebsiella (type of bacteria) ESBL (extended spectrum beta-lactamases-enzymes produced by certain bacteria that provide resistance to certain antibiotics (www.people.vcu.edu/~gbearman/Adobe files/ESBLgonzalo2.pdf)

PICC line: Peripherally Inserted Central Catheter: Medline Plus documents: A tube that goes into a vein

Proteus: Medline plus documents: A type of bacteria

Rocephin IM (intramuscular): Medline Plus documents: used to treat infections caused by bacteria

Suprapubic: Medline Plus documents: (tube) drains urine from your bladder. It is inserted into your bladder through a small hole in your belly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 30	F 315		

Tetracycline: Medline Plus documents: medication used to treat bacterial infections
Primaxin: Medline Plus documents: medication used to treat serious infections

On 9/29/16 at approximately 1:30 p.m., CNA (Certified Nursing Assistant) #104 was observed performing foley catheter care. The CNA initially explained the procedure to Resident #4. The CNA then washed her hands at least 20 seconds using soap and water. The CNA then obtained water in a basin. The CNA donned non-sterile gloves and proceeded to cleanse around the foley insertion site and cleansed down the foley tubing, using a different portion of the wash cloth. After rinsing the soap and water off with plain water, the CNA dried Resident #4. The CNA cleaned her supply areas, removed her gloves and washed her hands.
CNA #104 was questioned if she utilized leg straps to secure the foley catheter. CNA #104 stated, "I use the leg strap if the patient gets up. I don't when the patient stays in bed like (Resident #4)."
The facility 2001 Policy and Procedure titled, "Catheter Care: Urinary" documented the following: "Secure catheter utilizing a leg band." The Purpose of this Policy documented the following: "The purpose of this procedure is to prevent catheter associated urinary tract infections."

Resident #4 was observed to not have a leg strap on the following dates:
9/27/16 at approximately 11:05 a.m. and 9/29/16 at approximately 1:30 p.m.

The facility administration was informed of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 31 findings during a on 9/29/16 at approximately 4:30 p.m. The facility did not present any further information about the findings.	F 315		
F 332 SS=E	FREE OF MEDICATION ERROR RATES OF 5% OR MORE CFR(s): 483.25(m)(1) The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on medication pass observation, staff interviews, facility document review and clinical record review the facility staff failed to ensure they were free from a medication error rate of 5 % or greater. There were 25 observed medication opportunities with 3 errors, resulting in a 12% medication error rate. 1. On 9/27/16 LPN #3 (Licensed Practical Nurse) gave Resident #2 Ropinirole at 1:35 p.m. instead of at the scheduled time of 5:00 p.m. 2. On 9/27/16 LPN #5 gave Resident #19 Latuda at 4:14 p.m. instead of at the scheduled time of 6:00 p.m. and LPN #5 gave Latuda without a meal as prescribed. 3. The facility staff failed to administer the medication, Potassium Chloride ER (Extended Release) in the correct form based on the manufacturer's recommendation for Resident #16.	F 332	F 332: How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. A medication error report was completed for Resident #2 along with physician notification on 9/28/16. No adverse effects were noted. A medication error report was completed for Resident # 19 along with physician notification on 9/28/16. No adverse effects were noted. A medication error report was completed for Resident #16 along with physician notification on 9/28/16. No adverse effects were noted. LPN #□s 2, 3, &5 received educational corrective action on 9-28-16. How the facility will identify other Residents having the potential to be affected by the same deficient practice.	11/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 32 The findings included: 1. Resident #2 was admitted to the facility on /2/9/06 and readmitted on 6/26/12. Diagnoses included but were not limited to restless leg syndrome and congestive heart failure. Review of Resident #2's clinical record revealed an Annual MDS (minimum data set-an assessment protocol) with an ARD (assessment reference date) of 3/17/16. The resident's BIMS (brief interview for mental status) score was coded as a 9 which indicated cognitive impairment. The resident was further coded as requiring extensive assistance by one to two staff members to complete her ADLs and was incontinent of both bladder and bowel. On 9/27/16, during the medication pass at approximately 1:35 p.m., LPN #3 administered the following medications to Resident #2: Ropinirole .5 MG (Milligrams) for restless leg syndrome (unpleasant feeling in legs, strong urges to move legs) Tramadol 50 MG for Pain Cimetidine 30 MG for GERD (Gastroesophageal reflux) Gabapentin 100 MG for nueropathy (pain, tingling numbness in feet, legs) During the reconciliation process of the medications given and the physician orders the following error was revealed: Rospinirole .5 MG, 1 tablet by mouth twice a daily	F 332	All residents have the potential to be affected. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur. 100% of all licensed nurses will be in-serviced by the Director of Nursing, Assistant Director of Nursing, or Staff Development Coordinator on the Medication Administration Policy by11/4/16. The Director of Nursing, Assistant Director of Nursing, or Staff Development Coordinator will do a Medication Pass with 3 licensed nurses weekly (one on each shift) x 4 weeks, then biweekly x 4 weeks, then monthly x 1 to ensure medications are given timely, in the correct form, and as ordered. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. The Director of Nursing will report findings of the medication passes and any medication errors to the monthly Quality Assurance Performance Improvement Committee (members include: Committee Chairperson □ Administrator; Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative;	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 33 diagnosis restless leg syndrome. Review of the September 2016 MAR (medication administration record) noted the medication was scheduled for 9:00 a.m. and 5:00 p.m. Rospinirole was given to Resident #2 at 9:00 am and 1:35 p.m. during a medication administration observation on 9/27/16. An interview was conducted on 9/27/16 at approximately 1:45 p.m. and LPN #3 agreed that this was a medication error. LPN #3 checked the MAR, emailed the physician, looked at the overdose perimeters and notified the DON. The overdose perimeters was 62.1 MG per day. A Nursing note was written to hold the 5:00 p.m. dose of Ropinirole and to monitor Resident #2 for tremors, SOB (shortness of breath), fever, or sweating for 24 hours. On 9/27/16 at 1:50 p.m. the DON (Director of Nursing) stated, "This is a medication error and I will write a Medication Error Report." The DON presented the Medication Error Report dated 9/27/16 at 1:45 p.m. as the time of incident. The report included notification to the physician, charge nurse and the name of the LPN involved. The investigation and actions taken were described and documented, "staff member was distracted by other meds that needed immediate attention being delivered." LPN #3 was educated to check orders before administering pills, to check time before and after preparing dose. According to the Medication Administration Facility Policy last revised on 4/2010, Medications must be administered in accordance with the order, including time frame. Also, if a dosage is believed to be inappropriate or excessive for the resident...the resident's physician shall be contacted to discuss the concerns.	F 332	Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) x 3 months for further suggestions and/or follow up as needed. Completion Date November 4, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 34	F 332		

The Administrator and DON (director of nursing) were informed of the findings at a briefing on 9/29/16 at approximately 1:00 pm. No other information was submitted by the facility.

2. Resident #19 was admitted to the facility on 5/11/10 and readmitted on 2/15/11. Diagnoses included but were not limited to schizophrenia, major depressive disorder, bipolar disorder, and convulsions.

Review of Resident #19's clinical record revealed an Annual MDS (minimum data set-an assessment protocol) with an ARD (assessment reference date) of 12/01/15. The resident's BIMS (brief interview for mental status) score was coded as a 15 which indicated no cognitive impairment. The resident was further coded as requiring set up assistance by staff members to complete her ADLs and was continent of both bladder and bowel.

On 9/27/16, during the medication pass at approximately 4:14 p.m., LPN #5 administered the following medications to Resident #19:

Latuda 80 MG (milligram) for Schizophrenia/Bipolar
Oyster shell calcium 500 MG for a supplement
Luctulose solution 10 g/15MG as a laxative

During the reconciliation process of the medications given and the physician orders the following error was revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 35	F 332		

Latuda 80 MG, 1 tablet by mouth every evening with evening meal diagnosis schizophrenia. Review of the September 2016 MAR (medication administration record) noted the medication was scheduled for 6:00 p.m. Latuda 80 MG was given with a few spoonfuls of applesauce to Resident #19 at 4:14 p.m. during a medication administration observation on 9/27/16. A new order was made on 9/28/16 for Resident #19 to receive Latuda 80 MG, 1 tablet by mouth every evening with the evening meal diagnosis schizophrenia and scheduled for 5:00 p.m.

An interview was conducted on 9/27/16 at approximately 4:15 p.m., LPN #5 agreed that this was a medication error. LPN #3 stated, "We give Latuda with applesauce and resident did not get it with dinner."

On 9/27/16 at 4:45 p.m. the ADON (Assistant Director of Nursing) stated, "This is a medication error and I will write a Medication Error Report." The ADON presented the Medication Error Report dated 9/27/16 at 4:14 p.m. as the time of incident. The investigation and actions taken were described and documented, "staff member did not read order correctly." LPN #5 was educated about the importance of reading medication order and clarifying and administering medication.

According to the Medication Administration Facility Policy last revised on 4/2010, Medications must be administered in accordance with the order, including time frame.

The Administrator and DON (director of nursing) were informed of the findings at a briefing on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 36	F 332		

9/29/16 at approximately 1:00 p.m.. No other information was submitted by the facility.

3. The facility staff failed to administer the medication, Potassium Chloride ER (Extended Release) in the correct form based on the manufacturer's recommendation for Resident #16.

The findings included:

Resident #16 was admitted to the facility on 3/5/15. Diagnoses for Resident #16 included but not limited to, Atrial Fibrillation, Hypertension and Dementia.
Atrial Fibrillation - often called AFib or AF, is the most common type of heart arrhythmia. An arrhythmia is when the heart beats too slowly, too fast, or in an irregular way.
Hypertension - means high blood pressure. Having high blood pressure means the pressure of the blood in your blood vessels is higher than it should be.
Dementia - a group of symptoms caused by disorders that affect the brain. Symptoms may include memory loss, confusion, personality changes, and difficulty with normal activities like eating or dressing.
The Resident #16's annual Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 3/1/16 coded Resident #16 as not having the ability to complete the Brief Interview for Mental Status.
During the medication pass observation, on 9/28/16 at 9:50 am, LPN #2 (Licensed Practical Nurse) crushed the Potassium CL ER (Extended-Release) tablet, mixed it with water

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 37	F 332		

and administered the medication to Resident #16.

On 9/28/16 at approximately 1:00 pm, the facility provided a copy of the following documents with the following findings:

The Physician Order Sheet and the September 2016 Medication Administration Record for Resident #16 documented, "Potassium CL ER 10 MEQ (milliequivalent) Tablet (Potassium Chloride) 1 tab by mouth daily".

The drug manufacturer information on Potassium CL ER (Extended-Release) states, "Do not crush, chew, break, or suck on an extended-release tablet or capsule".

The medication label on the Potassium CL ER for Resident #16 stated, "Do not chew or crush. Contact pharmacist related to this med".

The facility policy and procedure on "Administering Oral Medications", source: "Nursing Services Policy and Procedure Manual, 2001 MED PASS, Inc. (Revised October 2010)", has no statement that addresses crushing medications.

On 9/28/16 at 3:10 pm, an interview was conducted with LPN #2 and she was asked to review the medication label on Potassium CL ER on Resident #16. LPN #2 stated, "I looked it up and found that I should not have crushed it. I should not have been dissolving it in water".

On 9/29/16 at approximately 9:30 am, LPN #2 provided a copy of the documents sent to the physician to request an order pf Potassium CL in liquid form. The new physician order dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 38 9/29/16 at 3:20 am stated, "Potassium CL 10 MEQ Liquid po daily". On 9/29/16 at 2:20 pm, an interview with the DON was conducted. The DON stated, "It should be given in liquid form". The DON added, "If it is a medication that is not supposed to be crushed, they should have it in another form". The facility provided a copy policy and procedure labeled. The Administrator and DON were made aware of these findings on 9/29/16 at approximately 6:40 pm, no further information was presented.	F 332		
F 371 SS=E	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.35(i) The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined facility staff failed to prepare and serve food under sanitary conditions. The finding included: During the 9/27/16 7:15 am initial kitchen inspection it was noted the floor under steam	F 371	F 371: How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	11/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 39 table and cooking area had broken and missing tiles. One of the wall air conditioners had a black substance around the unit. The floors under these two areas was a raised island with tiles. Many of the tiles were broken or missing. A surface that is not sealed is difficult to clean and can harbor debris and infectious organisms. At the time of the kitchen inspections the Administrator was present. He was interviewed regarding renovations in the kitchen. He stated that the building's owner had been negations with the facility but that the talks had broken down. At the 8 pm 9/29/16 meeting with the administrative staff the Dietary Manager stated that the area around the wall air condition unit had been cleaned. The Administrator stated it also appeared that the talks for kitchen restoration were back on track.	F 371	The tiles under the steam table and cooking area will be repaired by 11/4/2016 The black substance around the wall air conditioner was cleaned on 9-27-16. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur. The Administrator, Maintenance Director, or Dietary Director will audit for broken tiles in the kitchen and for cleanliness around the wall unit Air Conditioner weekly x 3 months. Issues found will be corrected. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. The Administrator, Maintenance Director, or Dietary Director will present the results of the Kitchen Environmental Audit to the monthly Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson □ Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 40	F 371	Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) x 3 months for further recommendations and/or follow up as needed. Completion Date: 11/4/2016	
F 425 SS=D	PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH CFR(s): 483.60(a),(b) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by:	F 425		11/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 41 Based on observations, staff interviews, and facility document review the facility staff failed to implement pharmaceutical procedures for the dating and disposing of 4 multi-dose medication vials on 3 of 5 nursing units. The facility staff failed to ensure 4 open multi-dose vials of Aplisol were dated when opened and discarded after 30 days according to manufacturer specifications. On 9/28/16 Medication Room observations were completed on all 5 nursing units with a nurse present and the following was found in the medication refrigerators: Unit 1: 1 opened vial of Aplisol no date on bottle, date on box 8/19/16, Lot #772984. LPN (Licensed Practical Nurse) #8 was asked what you should do when you open a multi-dose vial. LPN #8 stated, "Date the bottle." Surveyor asked, "How long is the vial good for?" LPN #8 stated, "I'm not sure, I will find out." Unit 3: 1 opened vial of Aplisol date on bottle and box 6/29/16, Lot #772984. LPN #2 was asked what you should do when you open a multi-dose vial. LPN #2 stated, "You date the bottle when you open it." Surveyor asked, "How long is the vial good for?" LPN #2 stated, "Until the expiration date." Unit 4: 1 opened vial of Aplisol no date on bottle or box, Lot #789289. 1 opened vial of Aplisol date on bottle and box 7/11/16 Lot #772984. LPN #7 was asked what you should do when you open a multi-dose vial. LPN #7 stated, "You date, time, and initial the bottle when you open it." Surveyor asked, "How long is the vial good for?"	F 425	F 425: How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. All out dated multi dose vials were discarded on 9/28/16 How the facility will identify other Residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur. The Director of Nursing, Assistant Director of Nursing, or Staff Development Coordinator will in-service 100% of licensed nursing staff by 11/4/16 on the pharmaceutical procedures for dating and discarding multi-dose vials within 30 days of opening. A 100% audit was completed on all nursing units for dated and expired medications on 10-3-16. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers will conduct an audit to ensure all vials are dated when opened and discarded within 30 days after opening. This audit will be conducted 2x/week x 4 weeks, then weekly x 4 weeks, then monthly x 1.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 42 LPN #7 stated, "It expires in 30 days." Each vial of Aplisol stated, "Once entered vial should be discarded after 30 days." The Aplisol box stated, "Once entered vial should be discarded after 30 days." Aplisol: (tuberculin PPD [purified protein derivative], diluted) is a sterile aqueous solution of a purified protein fraction for intradermal administration as an aid in the diagnosis of tuberculosis. www.fda.gov/downloads, Food and Drug Administration. The facility manufacturer package insert for the medication Aplisol documented in part, as follows: DOSAGE AND ADMINISTRATION Aplisol vials should be inspected visually for both particulate matter and discoloration prior to administration and discarded if either is seen. Vials in use for more than 30 days should be discarded. STORAGE Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency. The facility policy titled "Storage of Medications" revised April 2007 documented in part, as follows: Policy Statement: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: 4. The facility shall not use discontinued,	F 425	How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. The Director of Nursing, Assistant Director of Nursing, or Staff Development Coordinator will present the results of Medication Audit to the monthly Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson □ Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) x 3 months for further recommendations and/or follow up as needed. Compliance by November 4, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 43 outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. On 9/29/16 at approximately 7:35 p.m. a pre-exit interview was conducted with the Administrator, the Director of Nursing, and the Regional Nurse Consultant where the above findings were shared. The Director of Nursing and Regional Nurse Consultant were asked what they would have expected from the nursing staff. The Regional Nurse Consultant stated, "I would have expected the nurses to date the vials when opened and discard them after 30 days." Prior to exit no further information was provided.	F 425		
F 431 SS=E	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.60(b), (d), (e) The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431		11/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 44 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review the facility staff failed to ensure medications were stored in a locked compartment, and that only authorized staff to include nursing supervisors, charge nurses, licensed nurses, and other personnel authorized to administer medications in compliance with Applicable Law were allowed access to the medication storage area for 1 of 5 nursing units. The facility staff failed to ensure that the Medication Room and Medication Refrigerator on Unit 4 were locked. The findings included: On 9/28/16 at 3:45 p.m. this surveyor entered the nursing station for Unit 4 to check the medication room. There were no nurses at the desk but 3 CNAs (Certified Nursing Assistants) were standing in the hallway. The CNAs were asked about the whereabouts of the nurse and in unison stated she is coming up the hall now. LPN	F 431	F 431: How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. LPN #4 was given one on one directed in-servicing by the Director of Nursing on 9/28/16 ensuring that the medication room as well as refrigerator are kept locked. How the facility will identify other Residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What measure will be put in place or systemic changes made to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 45 (Licensed Practical Nurse) #4 entered the nurses station and was asked to see the medication room by the surveyor. LPN #4 reached for her keys to open the medication room door; however, the door was already unlocked and open approximately 2 inches. LPN #4 stated, "Oh it's already open, it shouldn't be, I have been away fighting the copier for 20 minutes." LPN #4 was asked to open the medication refrigerator. LPN #4 stated, "I don't have the key, let me get the other nurse." The medication refrigerator was checked by the surveyor and it was noted to be unlocked as well. The facility policy titled"Storage of Medications" revised April 2007 documented in part, as follows: Policy Statement: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: 7. Compartments (including, but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. 9. Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location. Narcotics requiring refrigeration should be secured to the inside of the refrigerator in a locked box. On 9/29/16 at approximately 7:35 p.m. a pre-exit interview was conducted with the Administrator,	F 431	that the deficient practice will not recur. The Director of Nursing, Assistant Director of Nursing, or Staff Development Nurse will in-service all licensed nurses by 11/4/16 on the Storage of Medications Policy that indicates that medication rooms and refrigerators containing drugs and biologicals shall be kept locked when not in use. The Director of Nursing, Assistant Director of Nursing, Staff Development Nurse, or Unit Managers will audit the medication rooms and refrigerators that contain medications 3x/week x 4 weeks, weekly x 4 weeks, then monthly x 1 month to ensure compliance. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. The Director of Nursing, Assistant Director of Nursing, or Staff Development Coordinator will present the results of Medication Room Audit to the monthly Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson □ Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 46 the Director of Nursing, and the Regional Nurse Consultant where the above findings were shared. The Director of Nursing and Regional Nurse Consultant were asked what they would have expected from the nursing staff. The Director of Nursing stated, "I would have expected the nurses to keep the door and refrigerator locked at all times." Prior to exit no further information was provided.	F 431	Coordinator; Rehabilitation Director; and Medical Records Director.) x 3 months for further recommendations and/or follow up as needed. Compliance by November 4, 2016	
F 441 SS=E	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.65 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441		11/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 47 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to establish an infection control program which prevent the onset and the spread of infections. 1. The facility staff failed to provide a sanitary environment to help prevent the transmission of disease and infection. 2. The facility staff failed to implement infection control practices (handwashing) during medication administration. The findings included: 1. On 9/28/16 at approximately 11:30 a.m. to 12:00 p.m., Unit 1 and Unit 4's Central Supply rooms were observed to be heavily soiled and to have clean supplies on a dirty floor that was also covered with paper debris.	F 441	F 441 How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The boxes of briefs were picked up and placed on shelving units, enema kit disposed of, debris cleared off of the floor, and the floor cleaned on 9-28-16 in Unit 1□s Central Supply room; The boxes of supplies and Jevity were picked up and placed on shelving units, plastic utensils and straws were cleared off of the floor, and the floor cleaned on 9-28-16 in Unit 4□s Central Supply Room; LPN #1 was given one on one in-servicing by the Director of Nursing on the Hand Washing / Hand Hygiene Policy and Medication Administration Policy on 9/28/2016 How the facility will identify other residents having the potential to be affected by the same deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 48 On 9/28/16 at approximately 11:40 a.m. Unit 1's Central Supply room was observed. Boxes of briefs and an enema kit were observed on the floor. The floor was observed to be soiled with dirt and paper debris. On 9/28/16 at approximately 11:15 a.m. Unit 4's Central Supply room was observed to be dirty. Boxes of supplies were observed stored on the floor. One container of Jevity (feeding supplement) was observed on the floor. Plastic Utensils and straws were observed on the floors. Unidentified brown and black dry substances were observed on the floor. The CDC documents: "Infection-control strategies and engineering controls, when consistently implemented are effective in preventing opportunistic, environmentally-related infections in the immunocompromised populations." The CDC also documents that the elderly are more at risk for developing infections. While on the tour of the facility on 9/28/16 at approximately 11:30 a.m.,with the Administrator and Maintenance Director, the Administrator called the Central Supply Manager and asked him to clean the Clean Utility rooms. The Central Supply Manager asked the Administrator, "Is it bad?" and the Administrator replied, "Yes, very bad." The facility administration was informed of the findings during a briefing on 9/28/16 at approximately 4:30 p.m. The facility Administrator stated that the Central Supply rooms had been cleaned. The facility did not present any further information about the findings.	F 441	All residents have the potential to be affected. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur. The Administrator will in-service the Central Supply Director by 11/4/16 on storing items on shelving units and keeping debris off the floor. The Administrator will also in-service the Housekeeping Supervisor and Housekeeping Staff by 10/21/2016 on the Cleaning and Disinfection of Environmental Surfaces Policy. The Director of Nursing, Assistant Director of Nursing, or Staff Development Coordinator will in-service all licensed nursing staff on the Hand Washing / Hand Hygiene Policy and the Medication Administration Policy by 11/4/16. The Central Supply Director or Administrator will complete a Central Supply Audit ensuring supplies are stored on shelving units, debris is off the floor, and floors are clean 2x/week x 4 weeks, then weekly x 4 weeks, then monthly x 1. The Hand Washing / Hand Hygiene Policy was updated on 10-16-16 to reflect handwashing to last 20 seconds. The Director of Nursing, Assistant Director of Nursing, or Staff Development Coordinator will do a Medication Pass with 3 licensed nurses weekly (one on each shift) x 4 weeks, then biweekly x 4 weeks, then monthly x 1 to ensure handwashing is occurring correctly during medication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 49 2. The facility staff failed to implement infection control practices of hand washing LPN #1 washed hands for only 5-6 seconds three times during medication administration with one resident. On 9/27/16 at 12:01 p.m. LPN #1 (Licensed Practical Nurse) was observed during Medication Administration Observation to wash hands for only 5 seconds two different times and 6 seconds one time with one resident. In an interview with LPN #1 following the Medication Administration Observation when asked how long she washes her hands stated, "My standard is 20 seconds and you are right I didn't wash for 20 seconds, I rushed my hand washing." In an interview on 9/27/16 at 1:20 p.m. with the Director of Nursing she stated, "My standard is to sing Happy Birthday song about 1 minute." She added, "The expectation is to wash longer than 5-6 seconds." The Hand washing/Hand Hygiene Policy with a revision date of April 2010 was presented by the staff . The policy reads, "Employees must wash their hands for at least 15 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: before and after direct resident contact. The facility policy entitled Administering Medications with a revision date of April 2010 was presented by the staff. This policy documented, "Staff shall follow established facility infection control procedures (e.g. for example:	F 441	administration and for at least 20 seconds. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. The Administrator or Central Supply Director) will present the results of Central Supply Audit and The Director of Nursing, Assistant Director of Nursing, or Staff Development Coordinator will present results of the Medication Administration Passes and issues to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson □ Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) x 3 months for further recommendations and/or follow up as needed. Completion Date: November 4, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 50 hand washing...) when these apply to administration of medications. "Hands must be washed for a minimum of 20 seconds as recommended by the CDC (Center of Disease Control). The facility administration was informed of the findings during a briefing on 9/29/16 at approximately 1:00 p.m. The facility did not present any further information about the findings.	F 441		
F 456 SS=E	ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION CFR(s): 483.70(c)(2) The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations over three days at the facility, staff interview, facility documentation review, and in the course of a complaint investigation, the facility staff failed to ensure equipment is in safe operating condition. Physical Therapy *hydrocollator temperatures were not monitored on a daily basis. *Hydrocollator: a medical device consisting of a thermostatically controlled water bath for placing bentonite (clay substance) filled cloth heating pads. The findings included:	F 456	F456 How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Facility pulled the Hydrocollater out of Service and discontinued this treatment modality on 9/30/2016. How the facility will identify other Residents having the potential to be affected by the same deficient practice. Facility pulled the Hydrocollater out of	9/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 456	Continued From page 51 During an observation of the facility's Physical Therapy Department on 9/27/16 at approximately 12:20 p.m. the temperature logs were checked for the hydrocollator from 9/3/15 through 9/27/16. Temperatures were not observed to be recorded during the following time periods: 2/18/16 to 2/27/16 3/24/16 to 3/31/16 4/1/16 to 6/30/16 The Rehabilitation Director #105 stated on 9/27/16 at approximately 12:20 p.m., "I began working here 3/2016. The hydrocollator was broken for awhile. I think it was March, 2016. I don't have a work order for repair." The Rehabilitation Director stated that the expectation for hydrocollator temperatures to be done is every day that it is to be used. The Maintenance Director stated on 9/29/16 at approximately 3:00 p.m. that he had no work orders for the Physical Therapy hydrocollator. The facility hydrocollator temperature and cleaning record documents the following: "Note: Monitor the temperature daily and record weekly. Temperature should be between 150 degrees and 180 degrees Fahrenheit per manufacturer recommendations with an optimal temperature of 160-165 degrees. ..." In addition, the Hydrocollator Monthly schedule log March 2016 documents the following: "Maintain copies of monthly schedule in (facility) Ops Manual. Fax completed Monthly Schedule to Home office on the first of the next month.	F 456	Service and discontinued this treatment modality on 9-30-16. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur. Facility pulled the Hydrocollater out of Service and discontinued this treatment modality on 9-30-16. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. Facility pulled the Hydrocollater out of Service and discontinued this treatment modality on 9-30-16. Completion Date: 9/30/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 456	Continued From page 52 The facility administration was informed of the findings during a briefing on 9/29/16 at approximately 4:30 p.m. The facility did not present any further information about the findings.	F 456		
F 465 SS=E	SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON CFR(s): 483.70(h) The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and in the course of a complaint investigation, the facility staff failed to ensure a safe and sanitary environment for Residents and staff. The findings included: During a tour of the facility on 9/28/16 at approximately 11:30 a.m. the following unsanitary environmental issues were observed: 1. Pooling water and cracked cement flooring in the facility laundry room. 2. Foul odor in Unit 3's shower room 3. Unit 4's Dirty Utility room hopper was observed to be leaking water and the floor was observed to have debris and missing base boards. The room's sink was heavily soiled and without soap and paper towels for handwashing. 4. Dirty handrails were found on Unit 2 5. Two cracked floor tiles were observed at top of	F 465	F465 How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The pooling water was cleaned up on 10-4-16 and the cracked cement will be corrected by 11-4-16 with the laying of floor tile. Unit 3□s shower room will be pressure washed by 9-28-16 and the soiled laundry bags/hampers were removed on 9-28-16 Unit 4□s dirty utility room□s hopper was repaired on 9-28-16 The debris in Unit 4□s dirty utility room was removed on 9-28-16 and the baseboards were replaced on 9-28-16 In addition, Unit 4□s dirty utility room sink was cleaned on 9-28-16 and soap and paper towels were placed on the same day. The handrails on Unit 2 were cleaned	11/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 53 hall way floor ramp (each measuring approximately 4 inches long by approximately 6 inches wide with approximately 1/2 inch deep). 6. Sharp edge was observed to a wall protector located in hallway outside of room 47. 1. On 9/28/16 at approximately 11:55 a.m. cracked cement flooring and pooled water was observed on the floor beside the washing machines. The Administrator stated on 9/28/16 at approximately 11:55 a.m. that a washing machine unit had been removed from the area of cracked flooring and pooling water. The Administrator and Maintenance Director both stated that they would work to resolve the pooling water. The Center for Disease Control documents that pooled water is a potential source for spread of waterborne microorganisms. 2. On 9/28/16 at approximately 11:35 a.m. a foul odor was found in Unit 3's shower room. Three bags were observed on the floor in the shower room. In addition to the three bags there were soiled laundry hampers observed in the shower room. Unit 3's Unit Manager stated on 9/28/16 at approximately 11:35 a.m., "Those (three bags on floor of shower room) are soiled laundry from Residents whose family does their laundry." The Unit Manager stated that Residents do use this shower room and that the soiled laundry is stored in the shower room as there is no place to store them. The Unit Manager stated that prior to a	F 465	on 9-28-16 The cracked floor tiles at the top of the hallway floor ramp were replaced on 10-3-16 The wall protector outside of Room 47 was repaired on 9-28-16. How the facility will identify other Residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur. The Administrator or Director of Nursing will in-service 100% of Certified Nursing Assistants, licensed nursing staff, laundry/housekeeping staff, and maintenance staff on the Maintenance Work Order Policy and the Cleaning and Disinfecting Environmental Surfaces Policy by 11-4-16. The Maintenance Director or Housekeeping supervisor will complete an Environmental Rounds Audit monitoring for compliance and issues related to water pooling, cracked cement, odors and debris in the shower rooms, leaking hoppers, hampers in shower rooms, baseboards in disrepair, dirty sinks, lack of soap and paper towels, dirty hand rails, cracked floor tile, and wall protectors in disarray 2x/ week x 4 weeks,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 54 Resident taking a shower, the soiled laundry bags and hampers are moved across the hall into another room. 3. On 9/28/16 at approximately 11:15 a.m., Unit 4's Dirty Utility room hopper was observed to be leaking water and the floor was observed to have debris and missing base boards. The room's sink was heavily soiled and without soap and paper towels for handwashing. Unit 4's Dirty Utility Room floor was observed to be heavily soiled with dirt and paper debris and the floor base tiles were observed loose and hanging from the wall and heavily soiled with dirt. The Center for Disease Control (CDC) documents: "Regular handwashing, particularly before and after certain activities, is one of the best ways to remove germs, avoid getting sick, and prevent the spread of germs to others." In addition, the CDC documents: "Infection-control strategies and engineering controls, when consistently implemented are effective in preventing opportunistic, environmentally-related infections in the immunocompromised populations." The CDC also documents that the elderly are more at risk for developing infections. The Administrator and Maintenance Director were asked if they thought anyone could wash their hands in this room and both stated, "No." 4. On 9/28/16 at approximately 11:40 a.m., dirty handrails were found on Unit 2 hallways. When walking on Unit 2, the handrails felt sticky and gritty.	F 465	then weekly x 4 weeks, then monthly x 1. Issues found will be corrected and also reported in the daily Interdisciplinary Stand Up Meeting 5x/week. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. The Maintenance Director or Housekeeping Supervisor will present the findings of the Environmental Audits x 3 months to the monthly Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson □ Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) for further recommendations and/or follow up as needed. Completion Date: November 4, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 55 During observations on the three days of the survey, multiple Residents, staff, and family were observed using the handrails on Unit 2. The Administrator and Maintenance Director on 9/28/16 at approximately 11:40 a.m. stated they would work to resolve the issue of dirty handrails as soon as possible. The facility administration was informed of the findings during a briefing on 9/29/16 at approximately 4:30 p.m. The facility Administrator stated that the areas above had been cleaned, fan had been placed in the laundry room to dry the pooled water in the floors and handrails were cleaned. The facility did not present any further information about the findings. 5. During the General Operations tour with the Facility Administrator and the Maintenance Director on 9/28/16 at approximately 11:20 a.m. two cracked floor tiles were observed at top of hall way floor ramp (each measuring approximately 4 inches long by approximately 6 inches wide with approximately 1/2 inch deep). The Center of Disease Control documents the following guidance: "Damaged, warped, buckled, or uneven flooring surfaces inside healthcare facilities can cause...stumble, trip, slip, or fall..." The facility Administrator and Maintenance Director both stated on 9/29/16 at approximately 11:30 p.m. that they will work toward eliminating safety hazards that were observed during tour of the facility.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 56 The facility administration was informed of the findings during a briefing on 9/29/16 at approximately 4:30 p.m. The facility did not present any further information about the findings. 6. During a tour of the facility on 9/28/16 with the facility Administrator and the facility Maintenance Director a sharp edge was observed to a wall protector located in hallway outside of room 47. After the surveyor stated that the sharp edge could possibly cause a cut to a Resident's leg when walking by, the Maintenance Director stated, "We will work toward correcting the problem." The facility administration was informed of the findings during a briefing on 9/29/16 at approximately 4:30 p.m. The facility did not present any further information about the findings.	F 465		
F 468 SS=E	COMPLAINT DEFICIENCY CORRIDORS HAVE FIRMLY SECURED HANDRAILS CFR(s): 483.70(h)(3) The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and in the	F 468	F 468	11/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 468	Continued From page 57 course of a complaint investigation, the facility staff failed to ensure that handrails are firmly secured. The findings included: During tour of the facility on 9/28/16 at approximately 11:45 a.m., handrails on Unit 2 near room #18 were observed chipped and loose. The Maintenance Director stated, "I'll get on resolving that matter." The Center for Disease Control document, "Slip, Trip, and Fall Preventions", documents the following: "Proper construction and maintenance of ...handrails...can reduce hazards." The facility administration was informed of the findings during a briefing on 9/29/16 at approximately 4:30 p.m.. The facility did not present any further information about the findings.	F 468	How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Handrail on Unit 2 near room #18 was sanded and secured on 9-28-16. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur. Maintenance daily checklist was modified on 9/29/2016 to include observations of chipped/loose handrails for the entire facility. For weekends, the Administrator will in-service nursing, housekeeping, laundry on completing work orders for any handrails that appear loose or chipped by 11/13/2016. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. The Administrator or Maintenance Director will present the results of Handrail Audits to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson □ Administrator;	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 468	Continued From page 58	F 468	Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) x 3 months for further recommendations and/or follow up as needed. Completion Date: 11/4/2016	
F 514 SS=E	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.75(l)(1) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and facility documentation review the facility failed to ensure complete and accurate medical records including readily accessible Physician Progress	F 514	F 514: How the corrective action(s) will be accomplished for those residents	11/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 59	F 514		

notes were maintained for 4 residents, Residents #2, 14, 8 and 18, in a survey sample of 24 residents.

The Findings include:

1. Resident #2 was admitted to the facility on 2/6/06 and readmitted on 6/26/12 with diagnoses to include *Diabetes Mellitus, **Heart Failure, and ***Anemia.

The most recent Minimum Data Set (MDS) assessment was a Quarterly assessment with an Assessment Reference Date (ARD) of 9/8/16 with a Brief Interview for Mental Status (BIMS) of a 3 out of a possible 15 indicating Resident #2 was severely cognitive impaired and incapable of daily decision making.

On 9/28/16 Resident #2's clinical record was reviewed for Physician Progress Notes. Physician Progress Notes for April 2016, June 2016, and August 2016 were not found in Resident #2's medical record.

On 9/28/16 at approximately 3:00 p.m. The Director of Medical Records provided printed copies of Resident #2's Physician Progress Notes for April 2016, June 2016, and August 2016. The Director of Medical Records stated, "I do audits on the clinical records with the assessment schedule so I know when the Physician Progress Notes are due and I send a copy of the audit and schedule to the resident's physician, I just had to print them."

On 9/29/16 at approximately 2:30 p.m. an

found to have been affected by the deficient practice.

Progress notes for Resident # 2 were obtained and placed on the chart on 9/28/16. Progress notes for Resident #14 were obtained and placed on the chart on 9/29/16. Progress notes for resident # 8 were obtained and placed on the chart on 9/30/16. Progress notes for resident # 18 were obtained and placed on the chart on 9/29/18.

How the facility will identify other Residents having the potential to be affected by the same deficient practice.

All residents have the potential to be affected.

What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.

A 100% audit was conducted for History and Physicals as well as physician progress notes for Unit 1 on 10-10-16, Unit 2 on 10-14-16, Units 3 & 5 on 10-18-16, and Unit 4 on 10-19-16. Results for Units 1 & 2 were sent to the physicians on 10-17-16, for Units 3 & 5 on 10-18-16, and Unit 4 on 10-19-16. A tracking audit for progress notes and History and Physicals was created showing resident name, History and Physical date, last progress note, physician name, audit date, and date of return for History and Physical and progress notes. State and Federal Regulations were provided to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 60 interview was conducted with Resident #2's Attending Physician. Resident #2's Attending Physician was asked, "When you come in to see a resident what time frame do you consider appropriate to have your progress noted printed and put on the resident's chart?" The Attending Physician stated, "I would expect my Progress Notes to be on the medical record in 3 to 4 days after I see the resident. But my server went down last year in 2015 due to spam, fixed it and in 4 weeks it happened again. Bought a new server and since December we have been steady." The facility policy titled, "Physician Services" revised August 2006 documented in part as follows: Policy Interpretation and Implementation: 3. Physician orders and progress notes shall be maintained in accordance with current OBRA (Omnibus Budget Reconciliation Act) regulations and facility policy. The facility policy titled, "Charting and Documentation" revised April 2008 documented in part as follows: Policy Statement: All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. Policy Interpretation and Implementation: 1. All observations, medications administered, services performed, etc., must be documented in the resident's clinical record. On 9/29/16 at approximately 7:35 p.m. a pre-exit interview was conducted with the Administrator,	F 514	physicians on 10-20-16. Medical record audits will continue monthly to ensure complete, accurate, and readily accessible records. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. The Administrator, Director of Nursing, or Medical Records Director will present the results of H&P and progress notes Audits to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson □ Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) ongoing for further recommendations and/or follow up as needed. Completion Date: November 4, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 61	F 514		

the Director of Nursing, and the Regional Nurse Consultant where the above findings were shared. The Regional Nurse Consultant stated, "This shall be addressed, I can promise you that."

Prior to exit no further information was provided.

*Diabetes Mellitus: a complex disorder of carbohydrates, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion by the beta cells of the pancreas or resistance to insulin.

**Heart Failure: A condition in which the heart cannot pump enough blood to meet the metabolic requirements of body tissues.

***Anemia: A decrease in quality hemoglobin in the blood to levels below the normal range or in the circulating red blood cells.

The above definitions were derived from Mosby's Dictionary of Medicine, Nursing, Health Professions 8th Edition.

2. Resident #14 was admitted on 2/9/15. Diagnoses for Resident #14 included but not limited to *Dementia and Hypertension (high blood pressure).

The Resident #14's annual Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 2/2/16 coded Resident #14 as having the ability to complete the Brief Interview for Mental Status (BIMS) with a total score of 4 out of 15, indicating severe cognitive impairment.

On 9/27/16 at approximately 1:00 pm, a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 62	F 514		

comprehensive review of Resident #14's medical record was conducted and found only one Physician Progress Note dated 7/22/15. No other Physician Progress Notes were found in the chart.

On 9/29/16 at 3:12 pm, the Director of Medical Records provided printed copies of Physician Progress Notes dated 2/12/15, 12/21/15, 2/18/16, 4/18/16, 6/17/16 and 8/16/16.

On 9/29/16 at 3:30 pm, and interview with the Director of Nursing (DON) was conducted. The DON stated that physician progress notes must be completed every 60 days. The facility policy on "Physician Visits" (Source: Nursing Services Policy and Procedure Manual, 2001 MED PASS, Inc. (Revised August 2006), stated, "The Attending Physician must visit his/her patients at least every thirty (30) days for the first 90 days following the resident's admission, and then at least every sixty (60) days thereafter."

The Administrator and DON were made aware of these findings on 9/29/16 at approximately 6:40 pm, no further information was presented.
*Dementia - a group of symptoms caused by disorders that affect the brain. Symptoms may include memory loss, confusion, personality changes, and difficulty with normal activities like eating or dressing.

3. Resident #8 was admitted to facility on 05/05/15. Diagnoses for Resident #8 included but not limited to Dementia, Failure to Thrive, and Depression.

Resident #8's Quarterly Minimum Data Set

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 63	F 514		

(MDS), with an assessment reference date (ARD) of 09/22/16 coded the resident with long and short term memory problems with moderately impaired-decisions poor; cues/supervision required with behaviors present but fluctuates.

On 09/28/16 at 11:30 a.m., during the review of Residents # 8's chart, there were no recertification progress notes readily accessible for surveyor to review. During the same day at 12:30 p.m., surveyor spoke with Medical Records Coordinator related to Resident # 8's chart not having progress notes accessible. The Medical Records Coordinator stated that she had just called the MD requesting Resident's # 8's progress notes. The Medical Records Coordinator then stated " That's nothing new, this has been an ongoing thing for him." Surveyor requested the most recent 5 recertification progress notes from Medical Records Coordinator, she replied, "I am working on it."

On 09/29/16 at 2:25 p.m., the surveyor requested the last 5 recertification progress notes for Resident #8 from (DON). The request was made earlier on 09/28/16 at 12:30 p.m. to Medical Record Coordinator but the facility was not able to produce the last recertification progress notes for Resident #8. The DON stated, "I'll see where she is in getting those papers to you." Progress notes missing from Resident's chart include the following dates: 12/16/15, 02/15/16, 04/14/16, 06/13/16 and 08/12/16.

On 09/29/16 at 4:25 p.m., the facility was not able to produce the recertification progress notes that were requested on Resident #8.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 64	F 514		

The facility administration was informed of the findings during a briefing on 09/29/16 at approximately 7:30 p.m. The facility did not present any further information about the findings.

The facility policy for " Physician Services " Source: Nursing Services Policy and Procedure Manual, 2001 MED-PASS, Inc. (Revised August 2006). Physician orders and progress notes shall be maintained in accordance with current OBRA regulations and facility policy. "Physician Visits" Source: 2001 MED PASS, Inc. (Revised April 2013). The Attending Physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter.

4. Resident #18 was admitted to facility on 7/22/14. Diagnosis for Resident #18 included but not limited to CVA (stroke), Seizure Disorder, Diabetes, Anxiety and Depression.

Resident Annual Minimum Data Set (MDS), with an assessment reference date (ARD) of 06/30/16, coded the residents BIMS score at 15 indicating no memory impairment.

On 09/29/16, during the review Resident # 18's chart at 12:00 p.m., there were no recertification progress notes readily accessible for surveyor to review.

On 09/29/16 at 12:15 p.m. the surveyor spoke to (Director of Nursing) DON and requested the last 5 recertification progress notes for Resident #18. Progress notes missing from Resident's chart include the following dates: 11/27/15, 01/27/16, 3/28/16, 5/26/16 and 07/25/16.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	**340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 65 On 09/29/16 at 3:30 p.m.,when the surveyor asked DON if she had the recertification progress notes for Resident #18 that was requested at earlier today she replied "still working on it". On 09/29/16 at 4:25 p.m., the facility was not able to produce the recertification progress notes that were requested on Resident #18.	F 514		